DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		15G703	B. WIN			10/09/	/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	8			TONE AVE			
ARC OF	NORTHWEST IND	IANA INC, THE	PORTAGE, IN 46368					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0000								
			WOO	000				
	This visit was for the post certification							
	revisit to the extended recertification and							
	state licensure su	urvey conducted on						
	August 24, 2012	•						
	114845021, 2012	•						
	Dates of survey:	October 5 and 9, 2012						
	Facility number:	: 003192						
	Provider number							
	AIM number: 2							
	7 Hivi Hamoor. 2	00300310						
	Surveyor: Chris	stine Colon, Medical						
	Surveyor III/QM							
	Surveyor III/Qiv	IKP						
	The following fe	ederal deficiencies also						
	reflect state find	ings in accordance with						
	460 IAC 9.							
	100 11 10 7.							
	Quality Review	was completed on						
		Shebel, Medical						
	1	i Sileuei, Medicai						
	Surveyor III.							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

H4ZU12

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		15G703	B. WING			10/09/	2012
	PROVIDER OR SUPPLIER			5475 ST	DDRESS, CITY, STATE, ZIP CODE ONE AVE GE, IN 46368		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	OULD BE COMPLET	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0248	be made available including staff of with the client, and the client is a mir Based on record facility failed to Support Plans (I residing at the graph of the gr	ient's individual plan must e to all relevant staff, other agencies who work id to the client, parents (if ior) or legal guardian. review and interview, the have updated Individual SP) for 4 of 4 clients roup home (clients #1, #2, lable for all staff who oup home. E: and #4's records were group home on 10/5/12 at ew of client #1's record current ISP dated of client #2's record current ISP dated of client #4's record current ISP dated of client #4's record current ISP dated of client #4's record current ISP dated to of client #4's record current ISP dated of client #3's record current ISP dated ther documentation was iew to indicate client #1, current ISPs were eff who worked with the sup home.	W024	48	The Individual Program Coordinator will develop the IS within 10 days of the IDT. The Service Coordinator will then ensure that all staff are trained this ISP and that the documen available at the group home within 10 days of its completio On a monthly basis the Lead Service Coordinator will monit the completion of training in comparison with the date of ea client's annual. This will ensure that staff are trained and that t ISPs and new objectives are in place.	d on tt is n. or ach e	11/08/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4ZU12

Facility ID: 003192

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G703	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	e survey pleted 9/2012
	PROVIDER OR SUPPLIEI	1	5475 ST	ADDRESS, CITY, STATE, ZIP COE FONE AVE GE, IN 46368		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
		vailable for the group				
	A review of client #1's record was conducted at the facility's administrative office on 10/5/12 at 12:45 P.M The record indicated a most current ISP dated 5/10/12.					
	conducted at the office on 10/5/1	view of client #2's record was lucted at the facility's administrative to on 10/5/12 at 12:55 P.M The rd indicated a most current ISP dated 12.				
	A review of client #3's record was conducted at the facility's administrative office on 10/5/12 at 1:05 P.M The record indicated a most current ISP dated 6/4/12. A review of client #4's record was conducted at the facility's administrative office on 10/5/12 at 1:25 P.M The record indicated a most current ISP dated 5/11/12.					
	10/9/12 at 1:45 the group home	th the Service (2) was conducted on P.M The SC indicated staff should have updated #1, #2, #3 and #4.				
	This deficiency	was cited on 8/24/12.				

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Event ID: H4ZU12

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PRINTED: 12/05/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A PUBLIC 00 COMPLETED		
		15G703	A. BUILDING B. WING	<u>-</u>	10/09/2012
NAME OF F	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST IND	IANA INC, THE		AGE, IN 46368	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR The facility fails			(EACH CORRECTIVE ACTION SHOULD BE	IE

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Event ID: H4ZU12

Facility ID: 003192

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPL	ETED
		15G703	A. BUI		·	10/09/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODTHWEST INDI	ANIA INIC. THE			TONE AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE		PURTA	AGE, IN 46368		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0436	483.470(g)(2) SPACE AND EQUE The facility must if repair, and teach informed choices eyeglasses, hearing communications and devices identified team as needed in the Based on observation interview, the fact repair of adaptive sampled clients (in the group home of t	JIPMENT furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary by the client. ation, record review and cility failed to assure the e equipment for 1 of 2 (client #1). : rvation was conducted at on 10/5/12 from 6:00 A.M Client #1 was eclchair, which was the right wheel rim ician's tape holding the in together. th Direct Support the Direc	WO		Home Health Depot delivered loaner chair for Anthony Martir use until his parts come in for chair to be repaired. To ensure future compliance, Service Coordinator will check wheelchairs twice monthly for three months, for any needed repairs for and monthly therea	n to his e	11/08/2012

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE : COMPL	
		15G703	A. BUI B. WIN	LDING		10/09/	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				TONE AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE		PORTA	GE, IN 46368		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		se for over a month		TAG			DATE
		ent. Plus one of the					
		ght wheel is broken."					
	1	,					
	An interview wit	th the Service					
	Coordinator (SC) was conducted on						
	8/22/12 at 6:30 P.M The SC indicated						
	client #1's wheelchair was broken and						
	needed repairs. The SC further indicated						
she was trying to get client #1's wheelchair repaired but she was having							
problems with the seating company. No							
further documentation was available for							
		te when client #1's					
		eelchair would be					
	repaired.						
		nt #1's record was					
		/5/12 at 12:45 P.M The					
		Medical notation dated					
		eelchair is too small and					
		ke. He needs one that s brakes and also is for					
		es it very difficult to clean					
		nis strength, Thank you."					
	mo teem and to i	Savingan, Thaini you.					
	This deficiency	was cited on 8/24/12.					
	_	d to implement a					
		correction to prevent					
	recurrence.						
	9-3-7(a)						
	y-3-7(α)						

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Facility ID: 003192

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL		
		15G703	B. WIN	G		10/09/	2012	
NAME OF P	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE			
APC OF	NORTHWEST INDI	IANA INC. THE			TONE AVE AGE, IN 46368			
		<u> </u>			NGE, IN 40300			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE	
W0448	483.470(i)(2)(iv)	LSC IDENTIFT ING INFORMATION)	+	TAG			DATE	
*********	EVACUATION DI	RILLS						
		The facility must investigate all problems						
	with evacuation drills, including accidents.							
		ation, record review and	W0	448	Community Services Area		11/08/2012	
		cility failed to investigate			Manager will re-train staff on completing fire drills. To ensur			
	•	vacuation drills for 4 of 4			future compliance, Area Mana			
	`	1, #2, #3 and #4) who			will monitor fire drills at least	_		
	reside at the grou	up home.			weekly for ninety days and at least monthly thereafter.			
	Findings include	:						
	A morning observation was conducted at							
	the group home	on 10/5/12 from 6:00						
	A.M. until 8:00	A.M						
	Interview with D							
	,	SP) #1 was conducted on						
		P.M When asked how						
	1	ked during the overnight						
		#1, #2, #3 and #4, DSP						
		is always only one DSP						
	working during t	the overnight shift."						
		20 A.M., DSPs #1 and #2						
	lifted client #1 or							
	transferred him i	nto his wheelchair using						
	a hoyer lift. At 7	7:00 A.M., DSPs #1 and						
	#2 lifted client #3	3 out of his bed and						
	transferred him i	nto his wheelchair using						
	a Hoyer (mechar	nical) lift.						
		th DSP #1 was conducted						
		20 A.M When asked if						
	staff were trained	d on a hoyer lift plan for						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	ETED
		15G703	B. WING			10/09/	2012
NAME OF I	PROVIDER OR SUPPLIE	D	S	TREET A	DDRESS, CITY, STATE, ZIP CODE		
			5	475 ST	TONE AVE		
ARC OF	NORTHWEST INC	DIANA INC, THE	P	PORTA	GE, IN 46368		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
		3, DSP #1 stated "Yes, we					
		people at all times when					
	using the Hoyer lift."						
	A review of clie	ent #1's record was					
	conducted at the facility's administrative						
	office on 10/5/1	2 at 12:45 P.M The					
	record indicated	l: "Hoyer lift Risk Plan:					
	[Client #1]Date: 9/12Desired						
	Outcome-Reason for the plan: To prevent						
	injury when mo	ving [client #1] from one					
	position/locatio	n to anotherHistory:					
	[Client #1] has	a history of decreased					
	mobilityBasel	line: [Client #1] cannot					
	1	nsition from wheelchair to					
		Intervention: When					
		ng Hoyer lift (2 people					
	_	ure that the brakes are					
	· /	n client safety at all times,					
		client unattended."					
	never reave the	enent unattended.					
	A review of clie	ent #3's record was					
		e facility's administrative					
		2 at 1:05 P.M The					
		l: "Hoyer lift Risk Plan:					
		te: 9/12Desired					
		on for the plan: To prevent					
		oving [client #3] from one					
	_	n to anotherHistory:					
		a history of decreased					
		olegiaBaseline: [Client					
	_	et in the transition from					
	wheelchair to an						
	locationInterv	rention: When transferring					

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	X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G703		00	(X3) DATE SURVEY COMPLETED 10/09/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	5475 S	ADDRESS, CITY, STATE, ZIP CODE TONE AVE .GE, IN 46368	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	using Hoyer lift (2 people assist). Make sure that the brakes are locked, maintain client safety at all times, never leave the client unattended."			
	A review of the facility's records was conducted on 10/5/12 at 2:20 P.M The reports of evacuation drills conducted from July 2011 to September 2012 indicated the following:			
	Emergency drill record dated 8/7/11 at 4:30 A.M.: "[Client #1]Time Required: 19 minutes 20 seconds[client #3]Time Required: 15 minutes 10 seconds[client #4]Time Required: 8 minutes 55 seconds."			
	Emergency drill record dated 11/15/11 at 5:47 P.M.: "[Client #1]Time Required: 5 minutes 40 seconds[client #3]Time Required: 5 minutes 38 seconds[client #4]Time Required: 6 minutes 2 seconds."			
	Emergency drill record dated 11/30/11 at 6:15 A.M.: "[Client #1]Time Required: 7 minutes 45 seconds[client #3]Time Required: 7 minutes 17 seconds[client #4]Time Required: 5 minutes 55 seconds."			
	Emergency drill record dated 3/30/12 at 6:10 A.M.: "[Client #1]Time Required:			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G703	A. BUI	LDING	00	COMPLE 10/09/2	
		130703	B. WIN		DDDEGG GUTY GTATE TID GODE	10/09/2	.012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE FONE AVE		
ARC OF	NORTHWEST IND	IANA INC, THE			GE, IN 46368		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		econds[client #3]Time		1110			DATE
		inutes 45 seconds[client					
	_	ired: 13 minutes 30					
	seconds."						
	Emergency drill	record dated 3/24/12 at					
	5:55 A.M.: "[Cl	lient #1]Time Required:					
	24 minutes 15 seconds[client #3]Time Required: 15 minutes 45 seconds[client #4]Time Required: 19 minutes 45 seconds."						
	Emangan av duill	record dated 2/24/12 at					
	"	record dated 3/24/12 at lient #1]Time Required:					
	_	econds[client #3]Time					
		inutes 45 seconds[client					
	_	ired: 19 minutes 45					
	seconds."	irea. 17 illinates 45					
	50001145.						
		record dated 9/10/12 at					
	_	ient #1]Time Required:					
		econds[client #2]Time					
		nutes 10 seconds[client					
		ired: 10 minutes 45					
	_	#4]Time Required: 8					
	minutes 21 secon	nus.					
	Emergency drill	record dated 9/11/12 at					
	"	ient #1]Time Required:					
	_	onds[client #2]Time					
		nutes 58 seconds[client					
	_	ired: 5 minutes 57					
		#4]Time Required: 3					
	minutes 17 secon						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G703		LDING	NSTRUCTION 00	(X3) DATE COMPL 10/09/	ETED	
	PROVIDER OR SUPPLIER		5475 ST	DDRESS, CITY, STATE, ZIP CODE ONE AVE GE, IN 46368		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	5:12 A.M.: "[Cl 17 minutes 20 se Required: 7 min #3]Time Required: 7 min #3]Time Required: 7 minutes 37 secon None of the reporproblems encoured drills. The Area Managinterviewed on 1 AM indicated shis clients who lived complete assistate home. The AM "always" only on overnight/sleep I facility investigate by staff, the AM no formalized in taken to evacuate facility analyzed times encountered drills, and conduct those times, the did not currently with evacuation conduct investig	orts documented any intered during evacuation				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15G703	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET A 5475 S	ADDRESS, CITY, STATE, ZIP C TONE AVE .GE, IN 46368	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	This deficiency was cited on 8/24/12. The facility failed to implement a systemic plan of correction to prevent recurrence.				
	9-3-7(a)				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		E SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
15G703		15G703	B. WIN			10/09/	2012
			p. ,, 12,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					TONE AVE		
ARC OF NORTHWEST INDIANA INC, THE					GE, IN 46368		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0449	483.470(i)(2)(iv) EVACUATION DITES THE Facility must is with evacuation of action. Based on observer interview, the factorrective action for 4 of 4 clients. #4) living at the Findings include A morning observer the group home of A.M. until 8:00 A.M. unt	nvestigate all problems rills and take corrective ation, record review and cility failed to take to address the drill times, (client #1, #2, #3 and group home. : rvation was conducted at ton 10/5/12 from 6:00 A.M Direct Service SP) #1 was conducted on P.M When asked how keed during the overnight #1, #2, #3 and #4, DSP is always only one DSP the overnight shift." 20 A.M., DSPs #1 and #2 at of his bed and nto his wheelchair using 7:00 A.M., DSPs #1 and 3 out of his bed and nto his wheelchair using	Wo	TAG 449	A request for 12.0 staffing has been requested. 11/27/12A second DSP has been working the overnight shift since 11/8/1 between the hours of 10 pm at 6am to assist with using the Hoyer lift and conducting fire dand other agency shift duties. ensure future compliance a second DSP will continue to be scheduled the overnight shift. Area Manager will continue to monitor fire drills weekly for on month and monthly thereafter look for any deficiencies in evacuation times.	g 2, nd Irills To e The	11/08/2012
	on 10/5/12 at 7:2	0 A.M When asked if					

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Event ID: H4ZU12

Facility ID: 003192

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00		E SURVEY PLETED			
		15G703	A. BUILDING B. WING		10/0	9/2012		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 5475 STONE AVE PORTAGE, IN 46368					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD BE CROSS-REFERENCED TO THE		(X5) COMPLETION DATE		
	clients #1 and #3	d on a hoyer lift plan for B, DSP #1 stated "Yes, we people at all times when lift."						
	conducted at the office on 10/5/12 record indicated [Client #1]Dat Outcome-Reason injury when move position/location [Client #1] has a mobilityBaseli assist in the transanother location transferring usin assist). Make su locked, maintain	nt #1's record was facility's administrative 2 at 12:45 P.M The : "Hoyer lift Risk Plan: e: 9/12Desired in for the plan: To prevent lying [client #1] from one in to anotherHistory: in history of decreased ine: [Client #1] cannot sition from wheelchair to inIntervention: When g Hoyer lift (2 people ire that the brakes are in client safety at all times, client unattended."						
	conducted at the office on 10/5/12 record indicated [Client #3]Dat Outcome-Reason injury when move position/location [Client #3] has a mobility; hemiple	nt #3's record was facility's administrative 2 at 1:05 P.M The : "Hoyer lift Risk Plan: e: 9/12Desired in for the plan: To prevent ving [client #3] from one in to anotherHistory: history of decreased degiaBaseline: [Client in the transition from other						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G703		A. BUII	DING	NSTRUCTION 00	(X3) DATE COMPL 10/09/	ETED	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5475 STONE AVE PORTAGE, IN 46368				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
TAG	locationInterversion using Hoyer lift sure that the brake client safety at all client unattended. A review of the fronducted on 10 reports of evacuation from July 2011 to indicated the following	ention: When transferring (2 people assist). Make tes are locked, maintain all times, never leave the l." facility's records was 75/12 at 2:20 P.M The ation drills conducted to September 2012		TAG	DEFICIENCY		DATE
	Emergency drill	record dated 3/30/12 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
15G703		A. BUII B. WIN	LDING IG		10/09/2012	
NAME OF P	PROVIDER OR SUPPLIER		D. WIIV		DDRESS, CITY, STATE, ZIP CODE	
					ONE AVE	
	ARC OF NORTHWEST INDIANA INC, THE			<u> </u>	GE, IN 46368	(7/5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE
	_	ient #1]Time Required:				
		econds[client #2]Time inutes 45 seconds[client				
		ired: 13 minutes 30				
	seconds."					
		record dated 3/24/12 at				
	_	ient #1]Time Required: econds[client #2]Time				
		inutes 45 seconds[client				
	#3]Time Required: 19 minutes 45 seconds."					
	Emergency drill record dated 9/10/12 at					
	4:32 A.M.: "[Client #1]Time Required: 15 minutes 15 seconds[client #2]Time					
	_	utes 10 seconds[client				
		ired: 10 minutes 45				
	seconds[client #4]Time Required: 8 minutes 21 seconds."					
		record dated 9/11/12 at				
	6:37 P.M.: "[Client #1]Time Required: 6 minutes 5 seconds[client #2]Time Required: 5 minutes 58 seconds[client #3]Time Required: 5 minutes 57					
		#4]Time Required: 3				
	minutes 17 secon	• •				
		1.1 / 10/04/10				
	"	record dated 9/24/12 at ient #1]Time Required:				
	_	econds[client #2]Time				
	Required: 7 minutes 24 seconds[client					
	#3]Time Requ	ired: 11 minutes 40				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
15G703		A. BUILDING B. WING		10/09/2012	
	PROVIDER OR SUPPLIEI		STREET . 5475 S	ADDRESS, CITY, STATE, ZIP CODE TONE AVE AGE, IN 46368	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) COMPLETION DATE	
	seconds[client minutes 37 seco	#4]Time Required: 9 nds."			
	AM indicated she clients who lived complete assistate home. The AM "always" only or overnight/sleep facility had idented action could be concerns, the Alactions were idented. This deficiency The facility failed.	ger (AM) was 10/5/12 at 2:50 P.M The ne was aware that some d at the residence needed once with evacuating the further indicated there is ne staff working the hours. When asked if the tified what corrective taken to address the time M indicated no corrective ntified or implemented. was cited on 8/24/12. The details of the prevent are correction to prevent.			

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